

77-001	\$25
77-006	\$ 5
TOTAL	\$30



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 24384 or (615) 532-3202, ext. 24384
www.tennessee.gov

APPLICATION FOR A SPECIAL TRAINING LICENSE AS A MEDICAL DOCTOR

APPLICANT: Provide the information required in the Personal and Competency Information portions of this application, sign, have the affidavit notarized, and then submit the entire application to the appropriate training program personnel. The sponsoring institution must submit this application simultaneously with all required documentation. It is vitally important that you provide the required documentation to the program personnel as early as possible. A profile questionnaire must also be completed and submitted to the board before licensure is awarded.

Applicant's Name:	(First)	(Middle and/or Maiden)		Last	
Date of Birth:	(Month) (Day) (Year)	Social Security Number: - - -			
Present Home Mailing Address:					
Home Phone:	()	- - -			
Residency or Fellowship Institution's Address:					
Work Phone:	()	- - -			

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **“Ability to practice medicine”** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnosis, and exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
 - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as amplifiers; and
 - c. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to: orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.
3. **“Chemical Substances”** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s directions, as well as those used illegally.
4. **“Currently”** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one’s functioning as a licensee or within the past two (2) years.
5. **“Illegal use of controlled substances”** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS

YES NO

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?

- a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?

- b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

COMPETENCY INFORMATION continued

QUESTIONS		YES	NO
2.	Do you currently use chemical substances?	_____	_____
	If yes, do they in any way impair or limit your ability to practice medicine with reasonable skill and safety?	_____	_____
3.	Are you currently engaged in the illegal use of controlled substances?	_____	_____
	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
5.	If you have ever held or applied for a license or certificate to practice medicine in any state, country, or province, has or was it ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7.	Have you ever failed a medical licensure examination?	_____	_____
8.	Have you ever applied for and been denied a state or federal controlled substance certificate?	_____	_____
	If you have possessed such a certificate has it ever been revoked, suspended, restricted, otherwise disciplined, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
9.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	_____	_____
10.	Have you ever been rejected or censured by a medical society?	_____	_____
11.	In relation to the performance of your professional services in any profession:		
a.	Have you ever had a final judgment rendered <u>against</u> you;	_____	_____
b.	Have you ever had settlement of any legal action rendered <u>against</u> you; or	_____	_____
c.	Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
12.	If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

AFFIDAVIT AND RELEASE

I, _____, M.D., of _____
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations that were enclosed in the application packet and agree to abide by them in the practice of medicine in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice medicine.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations that provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE

DATE

Sworn to before me this _____ day of _____, _____.

NOTARY PUBLIC

Affix Seal Here

My Commission expires _____

SPONSORSHIP INFORMATION

THIS PORTION OF THE APPLICATION MUST BE COMPLETED BY THE DEAN OR PROGRAM DIRECTOR RESPONSIBLE FOR THE TRAINING PROGRAM

I, the undersigned, am submitting an application on behalf of _____
(Applicant's Name)

to practice medicine in Tennessee with a special training license. **I am enclosing the following documents concerning this applicant with this application:**

1. An original medical school transcript sent directly from the applicant's medical school to me. [Note: the school's curriculum must be A.M.A. approved or for international medical school graduates, the medical school curriculum must be Tennessee Board approved pursuant to Rule 0880-2-.04(3). The transcript must show that the degree was conferred and it must bear the institution's official seal.] A notarized copy of the applicant's diploma will be accepted pending receipt of the original transcript.
2. A clear and recognizable, recently taken photograph of the applicant that shows the full head, face forward from at least the top of the shoulders up.
3. Two (2) original letters from medical professionals on the signatory's letterhead attesting to the applicant's good moral character.
4. Proof of the applicant's citizenship in the United States or Canada, or evidence of being legally entitled to live and work in the United States. (Notarized copies of birth certificates, naturalization papers, or J-1 visas.) For purposes of the J-1 visa, the Board will accept a temporary visa or its application pending receipt of a notarized copy of the visa itself upon issuance.
5. A check or money order in the amount of Thirty Dollars (\$30), payable to the Tennessee Board of Medical Examiners.
6. For International Medical School Graduates Only. A notarized copy of the applicant's original permanent E.C.F.M.G. Certificate. A notarized copy of the temporary certificate issued to the applicant will be accepted pending receipt of notarized copies of the original permanent certificate subsequently issued. [If the applicant is graduating from a Mexican Medical School, a letter from the E.C.F.M.G. stating that all certificate requirements have been met will be acceptable. If the applicant cannot obtain an original certificate due to the phase out of the E.C.F.M.G., proof of successful completion of the U.S.M.L.E. Steps 1 and 2 sent directly to you from the testing agency will be acceptable.]

Tennessee licensed physician(s) who will have primary supervisory responsibility for the applicant:

Name and License Number: _____

Name and License Number: _____

Sponsoring Medical School: _____

**DEAN'S OR PROGRAM
DIRECTOR'S NAME AND TITLE:**

(Please type or print)

SIGNATURE _____

DATE _____

Please mail to: Board of Medical Examiners
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

MA/G4028166/BME